Deafway

Brockholes Brow - Preston

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Brockholes Brow - Preston (Brockholes Brow) is a small community for adults who live with deafness, learning disabilities and mental health needs. The service is registered to provide a combination of accommodation and personal care for up to 34 people. The service comprises of four linked houses with shared and some single occupancy. The service is also registered to provide personal care to people in their own homes. There were 27 people using the residential service and 10 people using the domiciliary care service at the time of our inspection.

People's experience of using this service and what we found
People told us they felt safe and staff were kind and caring. However, our observations and findings showed that people did not always receive safe care and treatment. While safeguarding protocols were in place, they had not always been followed to report repeated falls and repeated incidents of self-harm. Risks to people were not adequately assessed and reviewed or used to make effective decisions on people's care. People at risk of unintentional weight loss had not been adequately monitored to reduce deterioration. People were not supported by suitably qualified staff to reduce risks of harm. Some parts of the premises were in a state of disrepair and infection prevention practices had not been adequately implemented in line with COVID-19 guidance. We were not assured by measures in place. The provider had not followed national COVID-19 guidance to facilitate people to receive family visitors. We observed people received their medicines safely. However, we found shortfalls in medicines management practices and record-keeping.

People were not always supported by staff who had the right skills and knowledge. Staff and the registered manager had not received training to meet the specialist needs of people they supported. People were not always supported to have maximum choice and control of their lives and staff had not always supported them in the least restrictive way possible and in their best interests. The policies and systems in the service did not always support the provision of care in the least restrictive practices and there was a lack of awareness on promoting decision making. People told us staff sought their preferences and referred them to advocates. Staff supported people to have access to health professionals and specialist support, however this was not consistent. Improvements were required to ensure people offered a variety of choice on their daily meals.

Right support:
- Model of care and setting maximises people's choice, control and independence

Right care:
- Care is person-centred and promotes people's dignity, privacy and human rights

Right culture:
- Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

The campus style model of service delivery offered to people at this setting does not meet current best practice. It is known that in large campus style environments that truly person-centred care which promotes people having meaningful lives where they have control, choice and independence is difficult to achieve. How the provider can modernise the service will be discussed following this inspection.

People told us staff were kind and caring and we observed some caring interactions between staff and people. However, practices in the service needed to be improved to ensure people were treated with dignity and their human rights were respected. Staff worked in partnership with people and their advocates.

The service was not well-led. There was a lack of oversight from the registered manager on the running of the service, in addition there was a lack of oversight on the running of the service from the provider who are the Board of Trustees. The registered provider needed to ensure there was skilful leadership to maintain regulatory oversight and monitor people's experiences and outcomes. The registered provider and the registered manager had not established a robust governance and quality monitoring system to continuously check and improve the safety of the care and people's experiences. The arrangements did not ensure the care model was reviewed in line with current models of care to promote a person-centred approach and the delivery of safe and high-quality care. Shortfalls were identified but not always resolved in a timely manner. Leadership in the home had established community links with local health and social care services.

People's care was not always designed in a person-centred manner as a result of the care model. People had been admitted away from their local counties against best practice guidance. People's care and experiences had not been adequately reviewed as a result. Care records were written in a person-centred manner; however, they did not always accurately reflect people's current needs and risks. Staff had not received training in supporting people towards the end of their life. We made a recommendation about end of life care. The provider had not adequately followed national COVID-19 guidance in relation to ensuring people could receive visitors in the home. People knew how to make a complaint, however improvements were required to ensure responses were person-centred and showed awareness of people's rights.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 17 September 2018).

Why we inspected
We received concerns in relation to health and safety arrangements at the service and the infection prevention and control practices linked to prevention of COVID-19. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with infection prevention and control measures to prevent the

spread of COVID-19, so we widened the scope of the inspection to become a comprehensive inspection which included all the key questions we inspect against.

We have found evidence that the provider needs to make improvements. Please see the safe, effective responsive and well-led sections of this report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold register providers to account where it is necessary for us to do so.

We have identified breaches of regulation in relation to keeping people safe from preventable harm such as falls, unintentional weight loss, monitoring clinical risks and safeguarding. The provider was also not meeting legal requirements in relation to seeking consent, responding to changes in people's needs, delivery of person-centred care, deploying suitably qualified staff and good governance at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the registered provider to understand what they will do to improve the standards of quality and safety. We will work alongside the registered provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the registered provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the registered provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the registered provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our well-led findings below.	**Inadequate**

Brockholes Brow - Preston

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the registered provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
One inspector and an inspection manager carried out the inspection.

Service and service type
Brockholes Brow - Preston (Brockholes Brow) is a combination of a 'care home' and domiciliary care service. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. This means that they and the registered provider was were legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who lived at the home about their experiences of the care provided. We spoke with eight members of staff including the registered manager, care coordinator, maintenance person, compliance manager and an interim manager on the inspection. We also spoke to the nominated individual for the service who is also one of the team leaders. The nominated individual is responsible for supervising the management of the service on behalf of the registered provider. We reviewed a range of records. This included 12 people's care records, multiple medication records, accident and incident records and four staff recruitment records. We looked at a variety of records relating to the management of the service. We walked around the service to observe the environment and interactions between people and staff.

After the inspection
We continued to seek clarification from the registered manager and to validate evidence found. We spoke to the Board of Trustees, local and out of county commissioners and the local safeguarding team. We sought feedback from health and social care professionals.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated good. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- The provider had failed to protect people from the risk of harm. Arrangements for assessing, reviewing and monitoring risks associated with repeated falls and unintentional weight loss were poor. We found incidents where people had experienced repeated unwitnessed falls and unexplained injuries. However, staff had not reviewed risk assessments to established ways to reduce the falls or to consider whether people needed to be referred to specialist professionals for further assessments to manage the risks. Staff had not monitored people for injuries following unwitnessed falls to identify any injury that may present after a fall.
- The provider had failed to monitor risks associated with nutrition. Staff made referrals to external professionals for specialist guidance. However, the registered manager and their staff had not adequately monitored people when they had lost weight, to track the risk of unintentional weight loss. We noted people had been weighed in January 2020 and not weighed until November 2020 regardless of identified risks of weight loss. Staff had not always received training and did not use best practice guidance such as the Malnutrition Universal Screening Tool (MUST), to monitor people's nutritional risks and needs. The service had failed to effectively monitor people who lived with diabetes and the specific diet they required.
- The provider had failed to carry out effective health and safety risk assessments in and around the premises. We observed parts of the premises including bathrooms and laundry rooms that were in a state of disrepair and mouldy. In addition, the registered manager had not carried out risk assessments in relation to the immediate environment around the home. There was a construction site adjacent to the service. While some temporary fencing had been erected, there was no evidence to show how the provider and the registered manager had considered risks associated with the excavation work. We asked the registered manager to take immediate action to address this.
- The provider had failed to protect people against the risk of infections. Staff were observed wearing personal protective equipment (PPE). Some parts of the premises were not clean, including areas with mould and parts of the toilets and bathrooms that were visibly not clean and stained. There was no adequate signage in the home to provide guidance to people and visitors about COVID-19. Some parts of the service did not have hand sanitising equipment such as alcohol gel dispensers or paper towels. A significant number of staff had not received up to date training in infection prevention and food hygiene. Infection prevention audits had been carried out, however they had not identified the shortfalls. While there were no cases of COVID-19 at the time of our inspection, the practices in the home exposed people to risk. We referred the home to the local Public Health Authority and the provider took immediate action to address some of these concerns.

The provider had failed to assess the risks to the health and safety of service users. They had also failed to ensure premises were properly maintained, including maintaining standards of hygiene, appropriate for the purposes for which they were being used. This was a breach of Regulation 12 (Safe care and treatment) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following our inspection visit, the provider confirmed that work within the environment to address health and safety concerns had commenced

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The provider had failed to protect people against the risk of abuse or improper treatment. The provider and registered manager had not effectively implemented systems and processes for safeguarding people, to ensure compliance with regulations and local safeguarding protocols. Not all staff had received training in the safeguarding of adults and the safe moving and handling of people. While staff reported some safeguarding incidents, we found a significant number of repeated falls, unexplained injuries and multiple incidents of self-injurious behaviour that staff had not reported to the local safeguarding authority, in line with local protocols.
●The provider had failed to implement internal safeguarding processes to ensure investigations were carried out to identify areas of improvement and risks of abuse. For example, we found staff had not shared incidents of unexplained injuries with relevant safeguarding authorities. The sharing of information would enable robust and transparent investigations to take place.
● The registered provider had failed to establish a robust system for facilitating staff to review and learn from incidents and near misses. This would enable them to improve practices and reduce the risk of repeated incidents. The registered manager carried out debriefs following some incidents, but these were basic and did not always show how staff were supported to understand risks.
● The processes for recording accidents and incidents was not robust. The registered manager had not exercised oversight on incidents and incidents were not always analysed to identify patterns and to ensure they were reported to external professionals where required. Robust recording of incidents would ensure incidents are appropriately investigated and areas for improvement identified and acted on.

There was a failure to report safeguarding concerns to authorities and protect people from abuse and inappropriate treatment. This was a breach of Regulation 13 (Safeguarding people from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The provider had failed to ensure the safe and proper management of medicines. We observed people received their medicines safely, however medicines management practices needed to be improved. Not all staff who handled medicines had received training in medicines management such as topical creams. Medicines records did not always provide clear guidance on how people's medicines, such as creams or eye ointments, were to be applied. Boxed medicines were not always dated when opened to ensure they would be disposed in line with manufacturer's recommendations.
● The provider had failed to ensure staff had clear guidance to support people who needed 'as and when required' medicines. This information is particularly important when people are unable to communicate that they are in pain. It gives staff indicators on how people display pain so medicines can be administered so people do not suffer pain.
● The provider had failed to ensure staff understood what action to take if people consistently refused their medicines.

We found no evidence that people's welfare had been significantly affected by unsafe medicines administration practices. However, systems were either not in place or robust enough to support safe medicines management. This placed people at risk of harm.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The registered manager followed safe staff recruitment procedures. All the necessary background checks were carried out. This ensured only suitable staff were employed to support people.
- We received mixed feedback regarding staffing levels within the service. The registered manager assured us they had been dealing with challenges due to staff absence and sickness but had access to agency staff to cover any planned and unplanned absence. We observed the service had appropriate staffing levels to keep people safe during the inspection.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- The provider had failed to adequately support staff with training into their roles and responsibilities. The provider had a system for inducting staff at the beginning of their employment, however we found this had not been effectively implemented and they could not demonstrate whether staff had successfully completed induction into their role as some of the staff were not on the training records.
- We found significant shortfalls in staff training, knowledge and skills. Staff had not always completed or updated training that the provider had deemed mandatory for the role. This included areas such as safeguarding adults, infection prevention, first aid, moving and handling, person centred care, equality and diversity. Catering staff had not completed training in infection prevention and nutritional awareness. The registered manager did not understand their responsibilities to ensure staff had the right skills and knowledge.
- The provider failed to provide staff with specialist training to meet people's individual and complex needs. They had not provided staff, including the registered manager, with relevant and specific training in line with the complex needs of people living at the service such as learning disabilities and autism, mental health, diabetes awareness and positive behaviour support. While the some of the training was impacted by COVID-19, we expected the provider to have provided or facilitated training in other areas using alternative methods such as e-learning, in line with national guidance.

The provider had failed to ensure all staff had received appropriate support and training to enable them to carry out their duties. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- The provider had failed to assess people's needs and choices in line with standards and guidance. We observed staff giving people choices. However, the registered manager and their staff had not consistently followed current legislation, standards and best practice guidance to achieve effective outcomes. This included national COVID-19 guidance on allowing visitors into the care home. In addition, consideration had not been made on following national guidance in modernising care models such as Right Care, Right Support, Right Culture. This guidance would ensure people received effective, safe and appropriate care which met their needs and protected their rights.
- Arrangements for supporting people with their oral hygiene were not effective. People did not always have

oral hygiene care plans and staff had not received training in this area.
● Staff had worked with healthcare professionals to ensure people's healthcare needs were met. They worked with local GPs, Nurses and Occupational Therapists to meet people's health needs. However, improvements were required to ensure people were referred to specialist professionals in a timely manner when their needs and risks had increased. We found this had not happened for two people.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection 11 people living at the home were subject restriction under DoLS.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff were not always working within the principles of the MCA. Staff had not completed capacity tests to check whether people could make specific decisions or required decisions to be made in their best interest where they lacked capacity. There was a lack of MCA training which impacted on staff knowledge and understanding of the principles.
● Restrictive practices were not well managed. In some cases, the registered manager had made applications to the local authority for DoLS assessments. However, applications had been submitted before the registered manager and staff had considered people's mental capacity to agree to the proposed decisions or restrictions.
● Whilst we observed staff seeking people's consent and giving them choice, the practices in the home did not always consistently promote choice and individualised approach to care.

The provider had failed to seek people's consent. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet;
● People were not consistently supported to maintain a balanced diet. While some people had been referred to specialist professionals to monitor risks associated with nutrition, risks with eating and drinking were not always monitored and reviewed regularly. Evidence from care records and our observations of practices at the service showed practices for promoting meal choices and alternatives were not adequate.
● There had been a period where people's weights had not been consistently recorded to track people's weight and the risk of unintentional weight loss. People had lost weight and actions had not been taken to review the impact on their well-being. We asked the registered manager to take immediate action to address this and identify people at risk.

Adapting service, design, decoration to meet people's needs
● People's individual needs were not always met by the design and decoration of premises. The registered provider followed a model of care delivery which was outdated and did not reflect best practice guidance.

The design of the care and the practices in the service resembled institutionalised practices which did not always assist people to be as independent as possible.

● The campus style model of service delivery offered to people at this setting does not meet current best practice and is not consistent with the principles of Right care, Right Support Right Culture. There was no consistent person-centred approach to care design and delivery. The provider needed to modernise the structure, design and model of care and set clear positive outcomes that promote individualised person-centred care.

The provider had failed to ensure people's care and treatment was delivered in a person-centred way. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Communal areas were provided where people could relax and spend time with others. Corridors were free from clutter, which promoted people's independence and a number of people were able independently use a local bus service to travel to the city centre with no staff support. There were adaptations in various areas to support people with sensory impairment.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People told us they were treated with kindness and were positive about the caring attitude of staff. However, our findings showed people's human rights had not always been respected. We found people's choice to control their lives had not been adequately promoted to ensure they could live as a normal a life as is possible. The provider had not followed COVID-19 visiting guidance to support people to have visits from their family and friends and promote their right to family life.
- Staff understood, and supported people's communication needs. They maintained eye contact and listened patiently and carefully when speaking with people to ensure their needs were understood. However, we found evidence which showed restrictions had been placed on people's access to their finances when they needed to use them, due to the administrative arrangements at the service.
- The approach to care delivery was not always dignified. We found an instance where a person had not been supported to attend hospital for emergency medical treatment due to staff shortages. We also found an instance where medicines for one person had been delayed being given, because permission was required from a manager before medicines could be given.
- While the service supported people, who lived with a disability and/or an impairment, staff had not received training in areas such as equality and diversity and confidentiality.
- Staff had attempted to support people to remain as independent as possible. However, we found this was not always consistent or supported by a positive risk-taking approach.

Supporting people to express their views and be involved in making decisions about their care

- The provider had processes for seeking people's views through meetings and surveys. However, this had not always been implemented and consistently acted on to demonstrate how people's views had been listened to.
- Professionals and advocates told us that they were involved in discussions about people's care.
- People were supported to access advocacy services. People can use advocacy services when they do not have friends or relatives to support them or want support and advice from someone other than staff, friends or family members.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

- People did not always receive care that was personalised to meet their preferences and choices. While some of the care records were designed in a person-centred manner, practices in the home did not consistently reflect a person-centred approach to care. We identified practices that that did not reflect awareness of individualised care. This included arrangements for accessing the community and people's ability to access and control their own finances in line with their choices.
- People's care records did not always reflect their current needs and circumstances. Some of the records we reviewed took account of people's likes, dislikes, wishes, allergies and there was a system for reviewing people's care needs. However, this had not always been effectively implemented to respond to people's changing risks and needs, to escalate changes in a timely manner. We found people's care records and how they were supported had not been reviewed following significant episodes such as increased falls or unintentional weight loss.
- We found not all care records accurately reflected people's risks and essential risk assessments such as nutritional risk assessments were either not in place or lacked detail for staff to support people effectively.
- Arrangements at the home did not adequately support people to prevent social isolation. The registered manager had established alternative ways of supporting people to maintain contact with their families such as video calling. However, they had not acted in line with government guidance to support face to face visits following change of policy in March 2021. People at the service were at high risk of isolation as a significant proportion of them had moved from other counties across the country. We asked the registered manager to take immediate action to make arrangements to allow visits in the home.

The provider had failed to ensure that people's care and treatment was delivered in a person-centred care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider and staff had arrangements and plans for people to take part in activities of their choice in the home and in the community. While restrictions due to the COVID-19 pandemic had impacted on the availability of activities, staff had established ways to support people safely with activities regardless of the COVID-19 pandemic including local day time trips.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are

given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The registered manager had assessed people's communication needs as required by the AIS. People could be provided information and reading materials in a format that suited their communications needs.
● Staff had not always received training to help meet people's communication needs. The service supported people who lived with deafness and other sensory needs such as sight loss. However, not all staff had received training around deaf awareness and communication. The training of staff would increase staff awareness of people's specific communication needs and improve their experiences.

● We raised these concerns with the registered provider. The registered provider told us they had faced some challenges in providing communication training to staff due to the pandemic and provided us with some assurances that communication needs had been considered and met.

We recommend the registered provider consult best practice guidance on meeting people's communication needs and review their practices.

End of life care
● People were supported to share their end of life wishes and we observed records which showed how people had shared their wishes. While there was a policy on supporting people to discuss their end of life wishes a significant proportion of staff had not received training in end of life care. We would expect this to be provided as the home supported people living with terminal, complex and life limiting conditions.

We recommend the registered provider consult best practice guidance on end of life care and review their practices.

Improving care quality in response to complaints or concerns
● The registered provider had a complaints procedure that was shared with people's relatives when they started using the service. The complaints policy was displayed prominently in the service.
● Improvements were required to the way complaints were received and investigated. Records of complaints did not always show how the complaints had been investigated. We saw complaints had been dealt with in line with regulations and measures had been put in place to address the complaint satisfactorily. Information was provided on what people could do if they were not satisfied with the outcome.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread shortfalls in the governance systems. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The registered manager and provider needed to improve their understanding of quality performance, risk and regulatory requirements. The registered manager did not demonstrate sufficient awareness of their role and responsibilities. We found they had not followed required standards, guidance and their own policies in various areas. They had not exercised their responsibility to ensure staff had up to date training and knowledge linked to the specific needs of people in the service.
- The provider and the registered manager had failed to have effective oversight on the delivery of care to identify areas of improvement in a timely manner. The arrangements between the Board of Trustees and the nominated individual was not set up to support accountability. We asked the provider to review their systems to ensure accountability and responsibility roles are appointed at the right levels.
- The provider had failed to implement systems and processes for monitoring the safety, quality and experiences of people to support the safe delivery of care. Arrangements in place had not effectively identified and dealt with some of the emerging and ongoing risks to prevent deterioration.
- The provider had failed to ensure their systems to assess, monitor and improve the service were operated effectively. Where audits had identified concerns, the findings were not used in a prompt manner to address and improve the safety and quality of care. For example, lack of suitably qualified staff had been identified by the provider's audits, however we found no evidence to show how this had been addressed as this was still carrying on at the time of our inspection.
- The provider had failed to implement systems for learning from incidents and near misses. The registered manager and their staff could not demonstrate whether they had reviewed what could be learnt from significant events such as repeated falls or incidents of self-harm.

The provider had failed to assess, monitor and improve the quality of the service and the safety and welfare of service users and others who may be at risk. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- The provider's governance arrangements did not promote the provision of high-quality, person-centred care which fully protected people's human rights. The model of care delivery had not been updated in line with the national personalisation agenda for people living with learning disabilities and mental health. There was a lack of awareness on the need to modernise the care model and the business strategy did not

show how the provider had considered this in their future plans. Systems for supporting staff including inductions, supervision and appraisals were not implemented to support the delivery of safe care.
● The provider had submitted some statutory notifications to CQC; however, we found a number of incidents of injuries that had not been notified and safeguarding concerns had not been shared with the local authority.

This was a potential breach of regulation 18 (Notification of other incidents) of Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People told us they were involved in the planning and review of their care. We saw evidence of people being supported to take part in meetings with specialist professionals including their doctors.
● The registered manager had close links and working relationships with a variety of professionals within the local area. Following the inspection, the Board of Trustees and the interim manager took immediate action to start addressing shortfalls we identified. They were committed to improve the care and people's experiences.